MEETING

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HEALTH AND HUMAN SERVICES AGENCY

RURAL HEALTH POLICY COUNCIL

CALIFORNIA CHAMBER OF COMMERCE

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8:30 A.M.

JAMES F. PETERS, CSR, RPR
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APPEARANCES

COUNCIL MEMBERS

Stephen Mayberg, Chairperson, Department of Mental Health

David Carlisle, Director, Office of Statewide Health Planning and Development

Kimberly Gates, Health and Human Services

Bud Lee, Rural Health Policy Council

Mickey Richie, Department of Health Services

Sandra Shewry, Managed Risk Insurance Board

Daniel Smiley, Emergency Medical Services Authority

Morgan Staines, Alcohol and Drug Programs

STAFF

Ernesto, Iglesias

Raquel Lothridge

Kathleen Maestas

Kerri Muraki

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PROCEEDINGS

CHAIRPERSON MAYBERG: Can we get started. I think we have lots of questions.

Good morning, I'm Steve Mayberg. I'm the Chair of the Rural Health Policy Council, a job I volunteered to do for six months, and four years later I'm still sitting here.

(Laughter.)

CHAIRPERSON MAYBERG: But I guess that is probably typical of issues in rural health that we identify an issue and think that it's going to get resolved quickly and it goes on and on and on. So I'm glad that at least we have some continuity here, and we'll try to deal with all the issues.

We have a reasonably ambitious plan today. We want to make several presentations and give you updates, but we also want to have the opportunity to hear what you have to say. For all of us here on the Rural Health Policy Council that turns out to be the most valuable part of our meetings is getting a sense of what the issues are in the real world, not in Sacramento, and allow us to take back to our respective departments your insights, your concerns, your agitation, your kudos occasionally to try and make the system be a little bit more responsive.

Before we begin, and before I introduce the rest

of the panel here, I have two announcements, and they're things that are really relevant to all of us now days. The first is the rest rooms are down the haul to your left, my left, your right. And the second, which is just as urgent to most of you, has to do with cell phones. You can't use your cell phone right here in this part of the building.

But if you need to use your cell phone, you can use it in the elevator lobby. And that's a request from the Chamber. And I understand don't understand the reasons, but it's great for me to be off the leash for awhile, so I'm really glad I can turn mine off.

With that, I'd like to introduce the -- have the rest of the group introduce themselves.

COUNCILMEMBER SHEWRY: Good morning. My name is Sandra Shewry. I'm the Director of the Managed Risk Medical Insurance Board. Probably we're best known we run the Healthy Families Program.

COUNCILMEMBER RICHIE: Good morning. I'm Mickey Richie with the State Department of Health Services. I'm the inter-governmental liaison in the Director's Office.

EXECUTIVE DIRECTOR LEE: Good morning. I'm Bud Lee. I'm the Chief Deputy Director of the Office of Statewide Health Planning and Development. And I'm also the interim executive director of this fine body.

COUNCILMEMBER CARLISLE: Hello. I'm David Carlisle, Director of the Office of Statewide Health Planning and Development.

COUNCILMEMBER SMILEY: I'm Dan Smiley. I'm the Chief Deputy Director For the Emergency Medical Services Authority.

COUNCILMEMBER GATES: I'm tardy.

(Laughter.)

COUNCILMEMBER GATES: Good morning. My name is Kimberly Gates. I'm Assistant Secretary with the California Health and Human Services Agency. The Secretary, Secretary Grantland Johnson sends his best and is pleased all of you were able to make it here early this morning, a little bit earlier than me to participate in the Rural Health Policy Council meeting.

CHAIRPERSON MAYBERG: We'll jump right in, since we don't have an executive director, I'd like to turn this over to Bud Lee who will talk about that issue and talk about everything that's been occurring with the Rural Health Policy Council.

EXECUTIVE DIRECTOR LEE: Thank you very much Steve. And thanks again for everybody to getup so early and get to the meeting this morning.

The first thing I'd like to do is just make sure that everybody recognizes the Rural Health Policy

Council's staff. As I call your name out, just in case you don't know them, Kathleen Maestas back there. Kerri Muraki, Ernesto Iglesias, And Raquel, where are you?

MS. LOTHRIDGE: Over here.

EXECUTIVE DIRECTOR LEE: There you are, Raquel Lothridge.

There's a number of things that I want to bring you up to date on, not the least of which is hiring the executive director, so that you could have a permanent full-time person on board in this job.

Then I'd also like to cover some other areas with regard to bioterrorism, the funding that's coming downstream, other activities that are going on in the Council having to do with the grants, the critical access hospital program and some other things.

But first and foremost I think an issue that is of interest to you as well as me. I want to give you the brief history of time of where we are with regard to hiring an executive director to fill this slot.

We were very close, I think within 24 hours, of having someone. We made an offer, this was in January, and he got an offer that he couldn't refuse from someone else. And so we're having to start again with regard to outreach and we're going to be looking for some help from all of you.

We've gotten a freeze exemption, so that's not holding us up anymore. In the back on the table and on our web page is a job opportunity bulletin where we are looking for someone from county or federal jurisdiction would be the most likely places. Someone that has experience in rural environments. It's called the arcane, kind of bureaucratic term, is inter-jurisdictional exchange.

It's a contractual arrangement between the State and a local or federal entity that we could hire someone via a contract to come on board here to be the executive director of the Rural Health Policy Council. We're advertising for this through a variety of rural associations.

If you would be interested you'd want to apply for a job if you worked for a county or if you worked for a local governmental jurisdiction or a federal jurisdiction, we'd be more than happy to talk to you about it. But that's where we are now.

That advertising is going to go on for another two to three weeks. We hope to have a candidate pool, an interview shortly thereafter. So if anybody is interested or if you know somebody who's interested, please don't hesitate to let them know about our interest and have them get in touch with me if they want any additional

information.

With regard to the bioterrorism funding is probably one of the hotter topics on the agenda now across the State. We are officially involved and on a planning committee. The Hospital Bioterrorism Preparedness Planning Committee has a lot of different stakeholders on it, including some from the rural community. I'm on the Committee. We're going into a conference call right after this meeting concludes.

Basically, there is a $10 million funding stream coming from the Centers for Disease Control through the Department of Health Services working with the Emergency Medical Services Authority. It's focused strictly on hospital, planning and preparedness funding. It's subsequently going to have a $60 million funding stream. It's going to be coming through to hospitals and other related entities.

There is seven areas that this funding is going to be focused on, planning and readiness assessment, surveillance and epidemiology capacity, biological lab capacity, chemical lab capacity, communications and information technology, health risk communications and information, and education and training.

I hope to have, in the not too distant future, an ability to communicate this to you via electric means. It

is so fresh that I don't have anything to really pass out to you on this yet. We hope that it's going to be on a web page of one of the government sites here fairly soon, so that you can see what's going on.

There is also going to be then in terms of additional funding down the road of $60 million, about 20 percent of that, or $12 million, is going to be allocated to planning, and about 50 percent to implementation. The remaining 80 percent or $48 million is going to be distributed upon approval of the workplan.

Our first task, and it's fairly near term, is to get, kind of, a preliminary plan into the Centers for Disease Control with the Governor's signature by April 1st -- I mean, April 15th. That's a rather large task.

Sheryl Starling is one of the leaders on this along with Jeff Rubin who works with Dan Smiley from the Emergency Medical Services Authority. Sheryl is giving a presentation tomorrow morning at a symposium at 9:30. She's the one that knows the most about this. And if you have any detailed questions of about this, she would be a good person to tap into.

Let me give you a rough idea of the timeline. After this April 15th submission to the Centers for Disease Control, then in July 1, we would be implementing the needs assessment. Hopefully, by September 15th, the

data would be compiled. And by about mid-October, we'd have an implementation plan.

December is for the first draft of the plan for review and feedback. And early next year the contracts for an allocation to the hospitals would be finalized.

So we've already fed some information into the very preliminary planning stages. Ernesto has been very helpful with me in terms of making sure that the rural interests are represented in these early stages. As you can tell, it's going to be a somewhat long and ongoing process, where we will be actively involved in that whole effort.

It is part of a much larger effort on the federal government's efforts to ramp up our ability to respond to bioterrorists incidents. And it really is part of a much larger effort with regard to anti-terrorism.

Any questions on the bioterrorism funding that's coming down the pike?

COUNCILMEMBER GATES: Bud, I think we have some comment.

COUNCILMEMBER RICHIE: Thank you. The funding that is coming down from the feds, the hospital piece is being administered by HRSA, and that is what Bud referenced to Sheryl Starling and the work group. The focus is on hospital bioterrorism preparedness.

The bulk of the funds are CDC administered and they do fall into those categories that Bud mentioned. The turn around time for the application is unbelievable. Kimberly has been helping us with making sure that we meet all these deadlines in a manner such that we can get all the okays and approvals, including approvals from the counties off to the feds by April 15th.

If you'd seen this application, they're very specific about how they want the money to be spent, but within those particular guidelines, each community is going to have to do their own assessment as to where they are.

And I know in the conference calls and the meetings that I participated in, there's a great deal of sensitivity to the fact that in a rural setting how you approach bioterrorism and how you pull your community together will be a little different than the urban areas, if not a lot different.

So right now we're working on the funding and the kinds of things that we can do within the federal guidelines and we should -- we will have something out on April 15th, but your counties have been -- the counties are an integral part of this. You can direct questions, if you needed to, to your county health leadership, because they've all been apart of it. So we're just real

anxious to see the final project. It's been a lot of work, but it's very encouraging.

EXECUTIVE DIRECTOR LEE: Okay, thank you, Mickey.

Other aspects of the Council's operation, I want to cover fairly quickly with regard to the grant program, the critical access program and other things that are going on. I'd refer you also to the table in the back has a number of documents that are also rather self-explanatory about what it is that I'm going to describe now.

With regard to the small grant program, the RFA for next fiscal year is going to be released on April 25th. It will be distributed by E-mail and regular mail and will also be available on our web site for downloading. The application due date for the small grants will be on June 14th and the copies again are available in the back.

The good news with regard to the rural small services grant program is that we've been notified by the State Department of Finance that roughly $1 million from Prop 99 funding has been changed from one-time funding to ongoing funding. So for the time being we don't need to worry about that funding going away.

Unfortunately, the $3 million, the annual appropriation for the rural development capital grants

program has always been a year-to-year appropriation, and it was not included in this year's budget because of the constraints on the general fund. But we have added links to our web site on alternative federal and philanthropic funding sources. And copies of those resources are also available in the back.

With regard to contract compliance monitoring, we've started to conduct site visits to monitor the contract compliance for both small and capital grants projects.

Contractors will be contacted before a site visit to their facilities, to set up an interview with the appropriate contact person.

On the rural jobs available service, currently we have 144 job adds listed in the jobs available database. And of these 144, 100 are for patient care positions, 11 for ancillary positions, and 33 are for administrative positions. Fifty-six percent of the 144 total job ads were placed in northern region providers and 34 percent were by the central and ten percent by the southern region.

And again, copies of that report are also available in the back of the room. And I think Dr. Carlisle is going to talk in just a few minutes here about the State's efforts with regard to the nursing initiative.

Finally, with regard to the critical access hospital program, I think most of you may be fairly familiar with this. There is written material on the back available with regard to the critical access hospital program. Its main intent is to maintain access to primary and emergency health care services, and to provide services that meet community needs and assure the financial viability of those hospitals through improved reimbursement and flexible operating requirements.

So far ten hospitals have been certified as critical access hospitals, two hospitals have been surveyed and are awaiting certification by Region 9 of CMS, and one hospital that we know of is also considering applying for certification.

With the first actual critical access hospital survey has been conducted and four other surveys will be done soon. And a continuation grant application for next fiscal year will be submitted in early May.

Just with regard to specific situations, Gridley has applied for State designation as a necessary provider hospital under the program. Their application is currently under consideration.

And Corcoran District hospital is preparing their application for State designation as a necessary provider hospital.

That is some of my report, unless there's any questions that anyone has of me about what's going on in the Council office.

Thank you very much.

COUNCILMEMBER CARLISLE: Okay. Well, I have two areas of comment. I want to speak first about the nursing workforce initiative announced by the Governor several weeks ago. And, secondly, just comment on the current status of the Seismic Safety Act Implementation that the office is going through, at this point, and many of you are responding to also.

First, I do want to say I apologize that I have to leave the meeting at 10:30 to attend another meeting, but will be here prior to that.

First about the nursing workforce initiative. As you all know, California is expected to face a deficit of about 25,000 Registered Nurses by the year 2006.

And in recognition of this growing crisis, the Governor announced the nursing workforce initiative several weeks ago. And this is a multi-component initiative, OSHPD, the office is involved in several fronts.

We've been collaborating with our partners at DHS, the Registered Nursing Board, Workforce Investment Board, EDD, Health Professions Education Foundation, on a

multi-faceted approach to the nursing crisis. And the Office has actually undertaken in a response on three different fronts.

We've been involved for some time with the Employment Development Department on a program called Career Ladders, and, basically, trying to incentivize individuals who are entering the nursing profession at some of the lower wrung, such as the nursing assistant level, to progress upward through the profession. And culminating, hopefully in receipt of a Registered Nurse's degree.

We've also been active for some time with the Health Professions Education Foundation in supporting nurses and nursing students who are in training through individual grants and loan repayment programs to augment other stipends, et cetera.

And most recently we've actually gotten involved in trying to develop a mechanism for incentivizing educational institutions to produce more graduates. And this is actually a major limitation in California. Our public institutions are fairly saturated in terms of their production capability.

And, of course, there aren't very many -- there's not a lot freedom in terms of producing additional educators in California. And so one of the real issues

facing us is how to encourage our educational institutions to produce more registered nurse graduates. And so we're working very closely with our partners in government and outside government to come up with some innovative solutions. So that's our role in the nursing workforce initiative.

And just finally, I wanted to announce for those of you who aren't familiar with this, in terms of this component of the seismic safety act. Of course, the original legislation says that by the year 2008, hospitals in the lowest performing structural category, SPC 1 need to move up to the next category, at least where they are no longer collapse hazards in the event of a serious earthquake.

Well, the legislation actually allows hospitals that have extenuating circumstances in terms of the provision of essential community services that would have to face closure if they're not able to meet the 2008 deadline, to apply for extensions under this particular clause in extenuating circumstances with the receipt or for the provision of essential community services. That would extend to 2008 deadline to 2013 at the latest.

And the Office has just recently issued a code application notice or CAN as it's known to the industry to advise hospitals how they actually might want to apply for

these extensions.

We've also initiated through our web site a public notification component of this, so that the communities that are served by these hospitals and others can note which hospitals have applied for and which hospitals have received circumstances under this provision of the Act.

We will implement a 45-day period for receipt of public comment after the receipt of each application before issuing an approval or denial as part of this.

So those are my comments, at this point. I'll go ahead and pass the microphone back to Bud unless others have questions of me.

Thank you very much.

EXECUTIVE DIRECTOR LEE: Well, I think I'm going to pass it back to Steve.

CHAIRPERSON MAYBERG: Are there any other departments who would like to make brief comments?

Mickey?

Sandra?

I'm we looking at the questions that we have received, I'm sure we'll all have ample opportunity to make comments when we get to the roundtable discussion.

I'd like to move on in the agenda to the next presentation about Coalinga State Hospital. I'm trying to

figure out how I want to phrase this. Now that I'm a rural health hospital administrator that we decided to go ahead and build a facility in Coalinga, in spite of all the things that you've told me about the difficulties of running an institution or running a hospital or running a clinic in a rural area.

But we did select Coalinga. It was a very intense process. It took us three years to find a site for our facility. And it was a combination of both who wanted us and where we wanted to go, because this is a facility for forensic mental health patients or more specifically sexual violent predators.

There were some NIMBY issues that we had to deal with. In 90 percent of the State, mostly in urban areas, no one was interested in having our facilities.

So we searched long and hard, and I think found a good marriage for us. But with any marriage there's always issues that need to be worked out. It certainly has nothing to did with the city or the location. It has more to do with the realities of providing health services in rural areas.

And so I'd like to introduce Tom Voss. Tom is the newly appointed executive director of Coalinga State Hospital. We hired Tom a few months back, and he's going to talk to you a little bit about what he's learned, about

what we're trying to do, what the issues are, what some of the challenges are, what some of the successes are in implementing this program.

And, you know, I think for all you, much like I said, I took this job, as a six-month job of chairing rural health policy. Little did I think that from start to finish the planning, financing, construction and staffing of a hospital would be a seven-year project, but it is.

And we brought Tom on board because we were at the stage now where it needs daily attention, hourly attention rather than some of the we'll get around to it when it's a crisis.

So with that, I'd like to introduce Tom Voss.

MR. VOSS: Thank you very much. Good morning, everyone. First, I'd like to thank the Council for the opportunity to be here today.

A little bit about myself. I've been in State service for about 25 years, primarily in the Department of Corrections, wherein I had some experience in designing and setting up programs for health care in the prison system, as we were expanding from 12 prisons to now, I think, it's currently 33.

So I had a little bit of experience in trying to get some of these health facilities up and operational.

With regard to this facility, Coalinga State Hospital is going to be a state-of-the-art treatment facility for sexually violent predators as well as forensic patients.

It was designed, as the Director said, over the past few years. And I have, to the right of me here, some of the computer drawings of the facility. The drawings that were done early on in the process. And then an update of some of the various facility and administration areas and so forth.

It will be a licensed acute psychiatric facility, joint commission accredited when we're done. It sort of looks like a prison on the outside, but inside it's very much a hospital. If you were to see the floor plans and how it was laid out and the functional adjacencies and so forth, you'd see very clearly that it is a hospital.

There's 1,500 beds altogether. There are four pods, what we all pods, located around the central core, support and programing area. These pods contain about 400 beds each.

The cost is in excess of $300 million in terms of construction. We anticipate hiring between 2,000, 2,400 employees by the time it's fully activated. And we anticipate an operational budget somewhere between $120 million and $150 million annually.

The challenges that we've had in this, as the

Director spoke to earlier, primarily began with location. The legislation that allows us to build this facility and activate it require that we locate it adjacent to a correctional facility, so that really limited us to about 33 sites throughout the State.

The Department of Corrections, the Department of Mental Health and the Department of General Services worked together on developing some criteria in the selection process. And when it was all distilled, it came down to primarily between two sites, Coalinga and a site in Imperial County.

And when the Environmental Impact Reports were done, and we looked at the level of community support, Coalinga was selected as the site. Some of the issues that we dealt with in that process were things like CDC baggage in terms of the Department of Corrections built here, but it really didn't help the community like we thought it would help the community.

So, of course, we had to overcome some of that. As the Director mentioned earlier, the NIMBY syndrome that occurs primarily in the urban areas.

And then many of the sites, the prison sites, were unsuitable either because there wasn't enough land available or they had plans for the land that they did have available. The final selection was based on the

lowest cost in terms of construction, the highest level of community support, which we received from Coalinga, the best ability to recruit staff in the area, and a lower operational cost overall.

Another area of concern or challenge that we faced was overcoming the sexually violent predator stigma and the issues that the community has with regards to security. The community concerns primarily evolved around the potential for escapes, road crews, whether we would be using this population to go and perform maintenance on the roads and outside of the perimeter of the facility.

They had concerns about transporting these patients through the community to, you know, access local emergency room and clinics from time to time. There was concerns about families of these patients locating the Coalinga area. And then finally there were concerns about when the patients were discharged from the facility then relocating to the Coalinga area.

Again, we held extensive meetings with the community. As you can see, it looks like a prison from the outside. And we provided them with information in terms of our perimeter, and how we're constructing it very much like a prison with the barbed wire around the outside.

We assured them that in accordance with the

legislation, the Department of Corrections would be providing the security perimeter, as well as the access entrance and exits of the facility will be control points that will be controlled by the Department of Corrections, correctional officers and employees.

We have currently slated about 160 hospital peace officers to be on staff and operate inside the fence in terms of the security there. We assured them that they would be doing the transports of the patients outside of the facility if they were ever to go outside of the facility.

We also explained in great detail our training for all of our employees in terms of security issues and how we operate the facility in terms of six daily counts, the lockability of the facility. We talked extensively about mutual aid in terms of the local police and the Department of Corrections should anything occur.

And, of course, the ongoing badges and other security systems and devices that we have throughout the facility, as well as the Citizen's Advisory Council that sits on these very issues and discussions.

The next area of concern is workforce development. As you know, Coalinga the distance to a high population pool is not very conducive to hiring large numbers of people. The significant Registered Nurse and

psyche tech shortage that there is throughout the State. And then we have the underdeveloped local systems, in terms of primary education centers have low testing scores, the low level of technical skills of the people in the community, and then inadequately prepared local community college type of an environment.

This gets into what Dr. Carlisle was talking about in terms of the Governor's nursing initiative. We've teamed up with a number of the local people and have engaged in what we call the central valley health career and training initiative.

And we put out -- or the State has put out about $6 million over the next three years to the local community college, which is West Hills Community College District, who's in partnership with the Fresno Community College, Lemore High School, Fresno Adult School and the Hanford Adult School, in terms of preparing the population, getting the adult skills up to get into the psyche tech schools and so forth.

The Department of Mental Health seeded this project with about a $650 thousand infusion into the West Hills Community College to get a psyche tech program up and going. And those first 45 students are already in the process of being trained, and they're well on their way to becoming licensed psychiatric technicians.

The next area of concern is the lack of housing and infrastructure in the city. It's interesting that the developers want to see the staff come on board and be available to buy houses. And the people that we're talking to who we want to come out to work at the facility are anxious to see that houses are being built, so we're working with the city and the local council on community development there to workup a marketing strategy in terms of marketing the area.

We're providing data in terms of our workforce level, our pay structures. We're working with the City in terms of stuffing envelopes with job fliers and informational bulletins. They have a web site that contains a lot of information about the facility and where we are and what we're doing. And we're spending a lot of time in the community talking to the leaders and talking to the business leaders of the community.

We're also working with our labor unions in terms of them coming up with ideas and assisting and helping us provide opportunity and notice to people who would be interested in working there, and talking up how the schools will improve over time and what the city's plans are to do that.

The other area of concern, of course, is what the impact of 2,400 employees would have on a community. The

increased sewage demands, water demands, the impact on schools and the other local infrastructure things. The Department has paid out already $6.9 million to the County of Fresno and to the City of Coalinga in mitigation funds, which have been paid upfront in terms of the impact on those local areas.

And probably the biggest area of concern for most people is the recruitment. The community expects us to hire, and that was part of the process all along, they want us to hire local people. The problem there is there's a small population base to recruit from and there's not a lot of skills available in that population. We have competition from the urban centers around, of course, long commutes, and the expectation on the part of community leaders that we hire from the community.

What we're doing in terms of trying to get the ball rolling down the hill on this is that we're providing local training in the area there for the population to understand what the State hiring process is like, because that's often a very long process, and it's very confusing to people who haven't been involved in it.

So we're going to train them on what the process is with respect to how it evolves over time and not to give up hope if you don't hear right away.

We're saturated in the local community with

advertising. We're conducting local hire interviews on site, once we get this thing going. So it's kind of high profile. People in the community can see that we're conducting interviews. There's a large number of people showing up in the offices that we establish in the local community there.

We, of course, are promoting the Central Valley Health Care Training Initiative and hoping that adults who are out looking for a job change or trying to get out of the agri-based businesses around there into a more technical field, trying to get them into the adult schools to increase their skills, build them up and create a pool to go up into the psyche tech training and the RN training that will be provided.

We're, of course, doing focused recruitment of professional in and around the area. We're developing a marketing plan with the City. We're stressing, you know, the low cost of housing, the low crime rate, the clean environment in Coalinga, and the local national parks that are within a commute distance and things of that nature.

We're, of course, working with the unions to look at recruitment incentive packages. It's something other than just a recruitment bonus at the end of each month. We're trying to look at other ways of making it attractive for employees of other departments and so forth to come

over to this facility.

We're talking of plans about improving local schools that the City is putting together. And, of course, we're talking to universities and colleges in terms of setting up residency programs and internship programs as the facility gets up and operational.

And, of course, an adjunct to our recruitment, we're looking closely at Telemedicine as a means to obtain primary specialty services. And hopefully these things will come to fruition.

We have a web site that's up and operational that keeps people informed in terms of what our status is, not only construction, but the hiring process and program development, and I'd welcome you all to take a look at. It's fairly interesting. They have photographs of where they are in the construction right now. It's just kind of grading the land, but as time goes on you'll see the buildings and so forth come up.

Unless you have any questions, that's all I have.

MR. HOHENBRINK: My name is Kelly Hohenbring.

My question is what has been the impact on the local hospital that's in that community? Clearly, the competition for recruiting nurses and workers to your facility has got to have a major impact on that hospital.

MR. VOSS: Well, interestingly enough, I've been

contacted by a lot of staff from the Department of Corrections, Department of Mental Health facilities and so forth. I haven't received any contact from any of the local Coalinga hospital employees.

One of the things we're trying to do through the Health Careers Initiative is to train a broad base of people. I think, there are 60 RNs we have planned over the next three years, about 500 psyche techs that will be going through that program. They're expanding it to include certified nurse assistants, occupational therapists, recreational therapists.

And we're involved in this, not just for ourselves, but there are a number of those people that will go through those programs that aren't interested in work with us, and we're certain that they'll end up in those facilities. So that program is kind of a tide that's going to raise everybody's boat. That's our hope.

CHAIRPERSON MAYBERG: I can respond a little bit more to that Tom. One, it was a concern we had that we would be the, sort of, the 600-pound gorilla and take all the employees from the other places. And it's turning out that many individuals really aren't interested in working in a State Hospital or working with sexually violent predators.

And what it has ended up doing is really given

some financial viability and stability to the other health providers because certainly bringing in a number of new employees to the area, and then needing to contract out for all of our specialty medical services allows the hospital layer to have a more stable funding base and allows them to recruit in that context.

And actually even the folks in Fresno are happy about this, because they figure any time you start bringing in a number of professionals, it changes the critical mass, and it's a little easier to recruit.

As all of you know, sometimes its difficult to bring someone in if they're going to be the only professional in the area, that they need peer support and coverage support. And so hopefully we'll be partners to be able to do that, and we don't get into a situation where we're competitive with other folks, and we're just sort of robbing Peter to pay Paul. And it doesn't do us any good if we have all the nurses and all the docs in our facility, and then can't have any health care services for all of our employees.

So it's a delicate balance, but it's a great question, and it's one we looked at early on. And if you're interested in how we analyze this, we do have all the documents and the Environmental Impact Report. And a lot of it had to do with the health professional shortage

and look at the analysis of where people are, what the educational facilities are turning out and drawing radiuses of 50 and 100 miles of what there is. And so we have looked at this, but it is a big problem as Tom says.

THE COURT REPORTER: Can he come to the mic please. I can't hear him.

CHAIRPERSON MAYBERG: I'll restate it for you.

(Thereupon the Mr. Miller asked a question from the audience.)

CHAIRPERSON MAYBERG: I need your name for the record.

MR. MILLER: Ned Miller.

CHAIRPERSON MAYBERG: And your question again was if the State was going -- I didn't hear the end of it, was going to provide?

MR. MILLER: They had talked to some people who felt the State was going to lease space from them in their adjacent medal office building, that that would help them, at least in the initial period, to work with the State in that way. I just didn't know if that was happening or is going to happen?

CHAIRPERSON MAYBERG: The question was did the State lease space from the local medical building in the interim while we're in the process of building?

MR. VOSS: What has happened is that the local

West Hills Community College District has taken almost all of the space there that was available. All they have now is a couple of very small areas. And it's this not sufficient to hold about the 20 people that we'll be bringing on over the next few months.

So we've looked at alternative sites in town there. One of them being the former city hall. Apparently, the county mental health operation they have going in the City Hall is going to be moving out of there around August, and that's space may be available for us to lease from the City.

MR. MILLER: Thank you.

CHAIRPERSON MAYBERG: Are there any other questions?

Thank you, Tom.

And we'll try and keep you up to date on this because I think the issues that Tom addressed, the issues of workforce development, workforce availability and how to maintain a small town and rural character with, sort of, the huge impact of a $350 million construction project and $120 million payroll present some unique challenges.

And it probably will be -- you know, we have pictures of what the facility is going to look like. It probably is a good idea for us to get pictures of what Coalinga looks like now and those of you who have been

there. It's a great looking town. It's just sitting in Pleasant Valley. Hopefully, it maintains its unique and positive character, that we don't urbanize it too much.

So with that, I'd like to go into I think for me what's the most edifying part of this is the sort of round table discussion and public comment. We've received a number of questions dealing with surprise, surprise workforce and dealing with bed availability, critical access and shortage of beds service availability, dealing with funding levels, adequacy of funding levels, dealing with bureaucratic slowness. As Tom was talking about people don't understand that the State speed is not freeway speed getting this done.

(Laughter.)

CHAIRPERSON MAYBERG: But we do go backwards well.

(Laughter.)

CHAIRPERSON MAYBERG: So what I'd like to do is I've got 15 questions here and that probably at the conclusion of those, if there's any issues that have not been discussed, we'll open it up to questions from the floor.

And I think the easiest way is just I'll give it to whoever is here who I think knows the most about it and they can, if they would read the name of the individual

and question and answer it, we'll go from there.

So Mickey you should be sitting closer to me, but we'll start with the questions.

COUNCILMEMBER RICHIE: Actually, I need a mic stand if we have one.

Could we have the two folks who filled out these cards, since I'm losing my voice, maybe speak to them rather than have me try to read their writing, which is not going to work.

Is it Jerry Fikes and Nancy Oliva.

COUNCILMEMBER GATES: Jerry, can you raise your hand more time. And Nancy is on the Rural Health Policy Support for J1 visa waiver alternatives. And, Jerry, is it Critical Access Hospital?

MR. FIKES: That's Correct.

COUNCILMEMBER RICHIE: Program that is intended to offer rural hospitals enhanced reimbursement. Why don't you go first, Jerry.

MR. FIKES: Good morning. I'm Jerry Fikes. I'm CEO at Mayers Memorial Hospital. We're about 70 miles east of Redding, and 85 miles west of Cedarville. So we're a light weight when it comes to being rural in comparison to some of our other colleagues who are Desperately rural.

My question was we've been encouraged by the

critical access hospital process on the federal side, in discussions with our medical staff, they ask me when is something like this going to happen on the State side, and is the State going to reinvent a different wheel to address the needs of rural hospitals in a way that the federal program has.

And the swing bed program is an example of that where our Medicare patients -- we're teaching our medical staff how to handle these patients and what all the criteria are and when it's a Medi-Cal patient it's big zero. They don't fit into those cubby holes at all. And it would be helpful for us to see the State try to model a program like that after the cause, since it's in place. If the federal bureaucracy can handle that, then there's some hope that the State bureaucracy could adapt to it as well.

COUNCILMEMBER RICHIE: So what you're asking for is if we're working on a program State level for the Medi-Cal program that looks like or is a cousin to the critical access hospital program.

MR. FIKES: Yes, with the similar premise behind it that if rural hospitals are going to survive they need some other reimbursement basis than our urban cousins.

COUNCILMEMBER RICHIE: Okay. I'm not aware of any, but I can check that out.

Nancy Oliva from Oak Valley Hospital District.

MS. OLIVA: Good morning. Oak Valley is located in Oakdale in Stanislaus County and the San Joaquin Valley.

We have the sixth largest number of migrant and seasonal farmworker family members and workers in the State. Our contiguous county has the fifth largest. Merced county our other contiguous county has a similarly large population of seasonal and migrant workers.

In the last four years in our district service area which covers 400 square miles of mostly field and orchard crop farms, four -- actually five of the nine physicians primary care physicians we have recruited have been J1 visa waiver recipients.

They have come to replace physicians, primary care physicians who have left the area, who have died or who have retired. As most of you probably know, there aren't a huge number of primary care physicians scrambling to work in certain parts of the central valley.

And, again, I probably don't need to remind you that our central valley counties probably produce about half the agricultural product, which is a multi-billion dollar product every year in California. So our agricultural workers are in low-income processing plant workers produce a good portion of the world's food and our

nation's food and our state's food.

We can't provide care for them as it is, and we're certainly not going to be able to provide care for them in the absence of international medical graduates. We can't meet the demand that exists now. And I'm sure most of you are familiar with the recently published California agricultural worker health survey. It's very clear that a number of agricultural workers needs again aren't being met by the current system, if we reduce the number of providers available to that population, now, which will happen. It is happening, because of the loss of the recent USDA announcement that they will not sponsor J1 visa waiver applicants.

I think we're going to further imperil the health of our workforce. And that may impact our agricultural work product in simple terms.

So, again, I know this is not news to you, but I would appreciate any kind of creative problem solving fairly rapidly that you can do for us, those of us in agricultural counties like Stanislaus, to facilitate the recruitment of international medical graduates one way or the other.

Thank you.

COUNCILMEMBER RICHIE: I'm writing and talking and reading all at the same time.

I know from years of discussion with this group and many other groups that the issue of workforce for the migrant farm workers and seasonal workers, the shortage of workforce, medical workforce in the central valley is an ongoing problem. And I do see a lot of interest brewing just within the last couple of years that I've never seen before, partially to your advocacy, I'm sure, both with the foundations, with the Department, personal interest on the part of our director, Dr. Diana Bonta, in working with both Mexico and the receiving communities. I've heard her speak so often of working with receiving communities, and sending communities, as far as the health concerns of the migrant workers are is a burgeoning issue.

And I will be bring this back, obviously, learning of the -- personally learning more about the J1 process and seeing what we can do to pull things together.

I guess I'm seeing this in steps, in maybe little steps rather than big steps or one program that solves a number of things, initiatives in the central valley, that I know the south part of the central valley is working on in public health and in the workforce.

So I guess I'm encouraged, but when you go home and you see your patient load and the lack of qualified medical personnel, it becomes overwhelming.

So thank you so much for your comments. And I

will take them back and definitely work together on the many ways that we're going to eat away at this problem.

Thank you, Nancy.

CHAIRPERSON MAYBERG: You have another J1 there.

COUNCILMEMBER RICHIE: Another J1. Gerald Starr, Interim CEO Sierra Kings District. That's a familiar name. Help manpower shortages physicians, J1, nurses and others.

MR. STARR: Should I cover all of those?

COUNCILMEMBER RICHIE: Sure.

MR. STARR: I just have a couple of questions here, that some might be directed to Dr. Carlisle.

Gerald Starr, Sierra Kings District Hospital.

J1 has been mentioned and just to increase the temperature on that a little bit on that concern, and ask you, as you review the program, the J1 program visa program under USDA, and, frankly, under the, what they call, the State 20 program, is a very onerous, bureaucratic processes. It's the most expensive, onerous process you could go through to document advertising trying to get an American-born physician.

You know, I would not, as a hospital administrator, go to the J1 program unless I had to. To go through that whole process to recruit a physician, to go through the Government process of filling out all of

those things is ridiculous. Somebody needs to think outside the box and how you get those people moving forward.

Another health shortages area, I would ask for very strong support for the tax credit for physicians willing to serve in rural areas, but would urge you to consider extending that credit to health profesionals who work full time in rural areas, nurses and lab techs would be a good example, also Registered Nurse practitioners.

And on the subject of bioterrorism, you better interface health profession shortages with that issue, is one of the recent commentaries in an editorial page in the newspapers said pumping millions of dollars into bioterrorism to take patients to emergency rooms that are under served because of lack of staff.

COUNCILMEMBER RICHIE: Absolutely.

MR. STARR: And you need to work on that.

Thank you.

CHAIRPERSON MAYBERG: Kelly.

MR. HOHENBRINK: Kelly Hohenbrink with Sierra. My issue as CFO of Sierra Kings District Hospital is merely, I've got an AR with the State. I've got to collect it.

The State owes us about three-quarters of a millions dollars. Half a million sitting in our 2001 cost report. Normally, that's not an issue, but the issue

comes down to it's all rural health. This policy change going to PPS for rural health reimbursement has us in a little bit of a bind. We started three clinics in, effectively, July 1 of 2000 or in the 2001 Period. They don't have the '99 or 2000 base years in order to get a rate.

There seems to be a lot of confusion when I talk to audits investigation as to what our rate should be, when should I expect to get a rate for these clinics, and it's really impeding our ability to plan for the future. It also impedes our cash flow, because I've got a 2001 cost report sitting out there with a substantial amount of money for our size hospital.

My other issue, other component of our receivable is the -- we have about a quarter of a million dollars due just on the 30 percent increase promised on Medi-Cal outpatient fee schedule. I know that there is a lot of discussion on getting that paid to hospitals, but we haven't seen it, and it would certainly help many of the small rural providers, getting that executed and getting paid.

So my real issues are what can we do about helping the audit investigation department figure out how to get the rates set for rural health clinics, especially hospital based rural health clinics.

COUNCILMEMBER RICHIE: The PPS rates for the new clinics, I think, is one of the tougher issues that we've had to tackle in going from cost based reimbursement to PPS. Kelly, if I could have your card, I'll see what I can do to walk this through for you, and see what we can do in the interim, at least to get things moving. I'll talk with our A&I folks and Medi-Cal folks on it, because we realize that with the switch over, you're right, based on previous cost reports, if you're brand new, we've thought of 101 ways to try to come up with something, and its really quite difficult.

But at the same time, we don't want to leave you completely in the lurch, so let's see what we can do on that.

Regarding the 30 percent on the outpatient, Kimberly maybe can you help me. I don't recall whether that's current year or budget year. It might be budget year. So I mean it's in the budget, and it's part of the settlement.

COUNCILMEMBER GATES: I'm A little foggy on whether or not it's current year or budget year.

COUNCILMEMBER RICHIE: Kelly, when you give me your card, I'll find out which it is. I think it's budget year and that might be why you haven't seen it yet.

COUNCILMEMBER CARLISLE: I just wanted to respond

to Jerry's question. With the question first, you mentioned tax credits for work in rural areas. Could you elaborate on that, because I'm frankly not really familiar with the tax issue.

MR. STARR: My feedback comes from a legislative representative -- my feedback comes from Kelly who participated as a legislative representative ACHT. They discussed the support of certain legislation that's been submitted, and one of those was tax credits for physicians serving in rural areas.

And when that report was given to our board, our board jumped on it immediately, don't think only of physicians. We've got a lot of needs. And put us on a level table with the urban hospitals, especially for rurals who are competing for folks who drive 35 or 40 miles to work in an urban hospital, instead of the rural hospital. It could make a difference.

COUNCILMEMBER CARLISLE: I should mention that we do have one program that you probably are familiar with already, which is the Health Professions Education Foundation, which does provide some loan --

MR. STARR: For Registered Nurse practitioners?

COUNCILMEMBER CARLISLE: Not specifically nurse practitioners, yes.

MR. STARR: I'm familiar with that a little bit.

We looked into it, and found out that it was just as financially onerous on the employer, on a hospital that has cash flow issues, as well as just as complicated as the J1 visa.

COUNCILMEMBER CARLISLE: For those of you who aren't familiar with the Foundation, you may want to look at our web site to learn more about it, but it does provide loan repayment support, scholarship support in return for service in underserved areas in California, and I think has placed recipients in approximately, at least 48 if not 50 counties in California, but thank you for those comments, and maybe we can talk some more about them.

CHAIRPERSON MAYBERG: Raymond Marks.

MR. MARKS: I'm Raymond Marks, CEO of Seneca Health Care District, which is in Lake Almanor, Chester, California, community 2000.

This is kind of a public comment, perhaps a little bit out of frustration. Two issues, nursing ratios. How we can pass a nursing ratio in a State when we don't have nurses is beyond me.

And two, I have a ten-bed hospital. My census usually runs less than six, but on occasions I get that 7th, 8th patient. According to the new nursing ratio, if I bring on that 7th or eighth patient, I have to add three

nurses, one around the clock.

They don't even live in the community. So it's an interesting challenge. So with regard to that, are there any plans to carve out the rural health facilities with regard to this particular issue. That's one.

And the other one is a seismic thing. And sitting here today I can't help wonder what happened to us, as a State. I mean, I really appreciate what's going on in Coalinga. I think it's wonderful. I've been in Coalinga. I've run a health facility in Coalinga, but $350 million. For one tenth of that amount, you could build a brand new rural hospital in over a dozen locations. For one-third of one percent, I could have a new hospital for what the State is spending in Coalinga to people that don't pay taxes.

What happened to our senior citizens that are retiring to these outward areas? We have a definite challenge. I mean, the extensions are great 2008 and 2013, but zero from zero is still zero. If we don't have the money to build, then the extension is kind of a moot point.

So it's a frustration. I mean the state hospitals, UC Davis you can spend a billion dollars to retrofit. We're districts who are a division of the State, but nobody has come up with any money for us, and

that's my frustration.

COUNCILMEMBER RICHIE: On the nursing ratios, it's my understanding that beyond the first documents that were released the first announcements, that there's other pieces of the how-to's that's coming out, don't quote me, but I think it's the middle of April or May. And I think a lot of the answers of situations such as yours might be in those documents.

If you give me your card, I'll see if I can give you some harder dates on that, since it's been a little white since I've been briefed on it. There, understandably, are all kinds of questions about circumstances, when the ratios fit, when they don't. And not all of those are smoothed out yet with the "i's" dotted and the "t's" crossed. It's going to take some time.

But, again, the fuller document, I think, is coming out this spring some time and may address some of those.

Thanks.

CHAIRPERSON MAYBERG: Judilee Smith.

MS. SMITH: Yes, good morning. I'm from Lompoc Health Care District, which is on the central coast about an hour north of Santa Barbara.

And, you know, our problem is also in recruitment

of nurses. We've had zero luck in working with the INS and the Department of Justice in bringing RNs from the Philippines to the U.S. They have denied their applications stating that we could fill our position with a two-year RN.

And the dilemma is that, you know, the scope of practice for an RN is the same no matter what your years of education are.

Also, on the nurse ratio, in talking with the director of nursing at our facility, it would be near impossible to meet those standards in our emergency department, and we would have to close services to people in our facility in our area.

Thank you.

CHAIRPERSON MAYBERG: I think we'll continue to hear a lot about nursing shortages. And that is one of the reasons that the Governor has identified nurse -- I think we'll continue to hear a lot about nursing shortages. And this is one of the reasons the Governor has identified an initiative about the nursing shortage issue, the one that Dr. Carlisle talked about.

But I think the more information you give us here, the more it helps us support pushing that initiative more expeditiously.

Vic Biswell.

COUNCILMEMBER RICHIE: Steve? Dr. Mayberg?

CHAIRPERSON MAYBERG: Yes.

COUNCILMEMBER RICHIE: Could I ask the woman who just spoke if I could have her business card?

MS. AVERY: I'm actually not Vic Biswell, but I put that card in because he was going to be a little bit late, so I'll just play his role. I'm Sharon Avery with the Rural Health Care Center.

It has to do with a critical access hospital. And in reference to what Jerry was saying, in years past we've tried hard to get the State to play in that program at the same level as the feds. I mean, at the federal level they recognize the problem of very, very small isolated, rural hospitals, and the fact that they're closing, and leaving thousands of square miles without any access to care.

So that's what the program is supposed to address, and so far California hasn't been interested in doing that.

This year is not a good year to ask for that, with a $14 billion deficit, so we're not. What we're asking for is a technical bill, AB 2217, Aanestad. That the conditions of participation for Medicare for critical access hospitals are very straightforward. All critical access hospitals across the nation meet those, in order to

be certified.

In California, however, Title 22, in some cases, are more stringent than the conditions of participation. And the bill asks for those Title 22 issues to be waived when they conflict with the federal conditions of participation. So I ask the Department of Health Services to please support that bill.

And on the J1 visa just real quickly, really the request to the State is each State can, I think, handle about 20 applications. The State stepped up on February 28th, and I know processed ten, but the field doesn't know it. And they need to know who to contact, how to get those applications in. Many people were in the very in-stages of doing their J1 visa applications, when the USDA said we're not going to do this anymore.

So help those folks, at least, and let people in the field know how to send those applications in for processing.

COUNCILMEMBER RICHIE: Sharon, if you would send me, copy me whatever letters and background pieces you have on the Aanestad bill, I'll make sure that our ledge people get them as well as the director and others.

Regarding J1, from my brief discussions with our rural division -- not a division, I get the categories mixed up still after two and a half years, it's big

department.

Our rural programs in our primary care and family health division, they are getting some of the USDA applications. So the word is getting out, but I will definitely take that back, be assured.

MR. HOHENBRINK: Can I ask a quick question. How many of the slots are available for J1 visa applications?

COUNCILMEMBER RICHIE: You mean, generally, annually my understanding is 20, unless someone has better information than I do.

MR. HOHENBRINK: Do you think that's an adequate amount?

COUNCILMEMBER RICHIE: It's a federal program. I mean, it seems like a real tight squeeze to me knowing the needs that are out there, but it's not the State's program.

MR. HOHENBRINK: I would think this room would consider that that number is way too small and it needs to be much larger.

COUNCILMEMBER GATES: What number, out of pure curiosity?

COUNCILMEMBER RICHIE: Take a shot at it, you brought it up.

MR. HOHENBRINK: A thousand.

(Laughter.)

COUNCILMEMBER GATES: Okay 21 from 1,000 or to 1,000.

COUNCILMEMBER RICHIE: Maybe they'll split the different with us.

CHAIRPERSON MAYBERG: I have a question, how many of you here in the room have used a J1 visa?

(Hands raised.)

CHAIRPERSON MAYBERG: So we have 20 already in the room. So I think one of the things we're seeing is it's much -- the use is much more prevalent than one would expect that 20 would be able to respond to.

Would that be an accurate summary, since we have 25 people who already use them?

COUNCILMEMBER GATES: And 21 slots.

CHAIRPERSON MAYBERG: And 20 slots. And you represent probably a very small percentage of the rural providers.

So I tell you that was a good visual.

MS. OLIVA: I'd like to reiterate what Kelly just said, 20 really is -- Nancy Oliva from Oak Valley Hospital District. Twenty is a drop in the bucket. Remember, we have a very rapidly growing State. And certainly in my county in which there are now almost 500,000 people, mostly, again, linked to the rural economy.

Our population has grown 20 percent in ten years.

We have a medical brown out. There are physicians leaving the State. Our physician to population ratio is much less desirable than it should be, so we're operating with a whole lot of restrictions as it is. I would say, again, at least 1,000 definitely, maybe 500. That would be a nice place to start.

CHAIRPERSON MAYBERG: Thank you.

MS. AVERY: And it's not just a rural program, this is in inner cities as well. I don't have a handle on the demand there.

CHAIRPERSON MAYBERG: As Sharon said, it's not just a rural program. It's a inner-city issue also, and it speaks to workforce shortage.

Judy Shaplin.

MS. SHAPLIN: Good morning. Thank you for the opportunity to speak before you. I am Judy Shaplin. I'm with Mountain Health and Communities Services out of San Diego. We're one of those rural areas in a metropolitan area that have some significant problems of even being recognized.

There are a few issues that I'd like to bring to your attention. Primarily, and not in any particular order, except for priority, because they're all urgent, one of the ones that we've really been trying to deal with, from our perspective as an agency, is the budget

impact that will happen come July 1, when there's no budget to be signed.

We are still grappling with the fact that the budget was not signed on time last year. The cash flow implications we barely survived. If it happens again this year, which all indications say that it will, I don't know if we'll be here. And I don't think we're the only ones across California in rural areas.

The cash flow from the State all of our State funding, Medi-Cal, CHTP, all -- everything that comes down, large rural grant stops July 1. It's only the past accounts receivable that we will get. That will not carry us through.

The only thing that saved us last year was the county continued to provide funds through the contracts we have with the county. We have been told by the CAO's office out of San Diego, the County will not pay on County contracts when the State budget is not signed on time.

I have already begun layoffs. I've laid off three providers, physicians, physician's assistants. We have closed down chronic disease management access. This is in a rural area of 950 square miles. We service 16 small communities. We do not have a hospital. We do not have a pharmacy.

This is a truly enormous impact. And everyone

needs to understand access to health care is our primary mission.

The PPS payment that has not been put into effect for rural health for cost reimbursement, we were counting on this all year long. We're still outside. Nobody has said when this will happen.

The retroactive to January 1st of 2001, if that is paid, some time before June, that might help. It might. But the question is is why hasn't it been done. It's been enacted, and I'm not the only rural health clinic who is desperately looking for this. It is a difference of about $20 per visit for us. That's a huge increase.

The other thing is the CHDP potential program going away. With the Healthy Families the expansion with no money for outreach programs is attached to that. We have a county contract for outreach. We have 12 outreach workers that will sunset June 30th.

We put over 6,000 families into the Healthy Families program in two and a half years. It has taken an enormous of amount of resources and effort to begin the program to stop June 30th. And then with the expansion going on, then say, oh, we need to have outreach programs again, and then the recreation of programs are already in existence makes no sense.

And if you're going to expand one program, don't defund another. You have to look at cause and effect of this.

The mental health, this issue, has been coming up again, the marriage family therapist cannot be billed under a community health center for Medi-Cal reimbursement. If they're outside of the community health center, they can reimbursed for Medi-Cal. I think that we need to look at this mechanism, LCSWs which is the only one that can be reimbursed besides psychologists are virtually nonexistent in the rural area.

We have been recruiting for over a year and a half. And there are some rural areas that have been recruiting over five to six years for an LCSW. The marriage family therapists are more readily available. They're not easily available, but more readily. Help us have the mechanism to provide the services that are desperately needed in this area, so that we can combat the drug and alcohol issues, the domestic violence, the child issues that we have.

J1 visa, we have a medical director under J1 visa. The program is onerous. I was shocked at figuring out how much it cost us, the time that was spent. It took us one year to go through the paperwork and have this physician in. He's Board Certified Internal Medicine, and

Board eligible pediatrician. In a rural area, he was a Godsend. There's 15 in San Diego county who are duly boarded like that.

It is an enormously valuable asset. I was in Washington D.C. on rural policy issues conference a couple weeks ago, March 2nd, when we found out about the J1 visa program. But the question was asked of the legislative offices, we're not sure about the people who already are approved. Not only have they done away with the program, but the question came up, we're not even sure if the ones who are approved are going to be retained. That's a devastating thought, since, you know, we're in the six months of this five-year process.

The other medical or executive director I was with out of Borrego Medical Center, they have six months left for their J1 visa. It impacts not only the agricultural in central and northern California, it impacts everyone in rural, and, as Sharon said, in the inner cities.

COUNCILMEMBER RICHIE: Judy, what do you mean by six months left on their J1 visa?

MS. SHAPLIN: The agencies, the organizations and the physician sign a contract with each other, and they have so many years that they have to provide services in the health personal shortage area. So that's what it is,

their contract period is almost up. We're only six months into our five-year contract.

The drug and alcohol issue, and I apologize for taking up all your time.

CHAIRPERSON MAYBERG: Yeah, you are going to have to speed up little bit, because we've got a lot of people who do want to talk.

MS. SHAPLIN: Drug and alcohol, I'm just in the process of doing medical reimbursement for drug and alcohol counselor. I was surprised to find the application to be reimbursed for Medi-Cal is the same application I filled out for Title 22 certification, but I have to go all the way through the process again just to reimburse Medi-Cal for drug and alcohol counseling.

I really think the Departments need to talk to one another. If you're already a Medi-Cal provider, why are we duplicating and recreating the same steps.

The bioterrorism, the border issues are across the Board. I appreciate the fact the hospitals need the planning money, but the clinics also, especially those clinics who have no hospitals in the area.

We are a border State, two of my clinics are right on the border. We were infamously I in the national news while back with the tunnel between Mexico and Boulevard. Boulevard is in our area.

We do have this conduit between this. We were awarded money for training for our volunteer fire departments in north and east county. And now there's some confusion that incorporated areas now mean rural in San Diego county, because they would like a piece of that money.

I really appreciate your time and energy listening to all of this. You know, we'd like to bring you solutions, but I also want to share some of the peoples that we have.

Thank you.

CHAIRPERSON MAYBERG: Thanks, Judy. I can respond to a couple of those. The issue of the budget being signed on time is critically important to all of us. And it really behooves you to let your legislators know the impact of the budget stalemate, what it means in real terms of people not being served, people not getting paid, and it has the most impact on small businesses and on individuals.

And we in Sacramento need to be reminded of that. So start working on that issue right now. Don't wait till June 20th to say do something. Let people know as they move forward that they need to move quickly.

I think we've heard a couple issues about payment of the rate increase. And, Mickey, I think we're going to

have to look into that and see what the status is on that, that cash flow is an issue.

There are two questions about Medi-Cal, one about alcohol and drug, and one about mental health.

First on the mental health, there's consolidation. And the way the law is written actually the only people who can provide Medi-Cal services are licensed psychologists and physicians. LCSWs cannot provide those services, or MFTs, or a certified clinic can supervise those, in that your local mental health program can certify you as a provider, but as an individual only those two disciplines are eligible for services.

So part of it, I think, has to do with the whole issue of utilization review and quality assurance and approval.

And the same is true for the drug and alcohol system. Part of why you go through a parallel process, we need to streamline that process, is that we need to make sure that people who are providing services are skilled in those particular services, that too often people sometimes expand their concept of what their capabilities are, in that we want to make sure that people who provide drug and alcohol services have skills in substance abuse services. People that provide mental health services are trained and have the requisite background and so that's why you have a

parallel processes.

The other thing you need to know about both the mental health and drug and alcohol system is that their allocations are capped. It's not an entitlement, and so there's only a finite amount of money. And so I think almost all areas target particular groups for services. And more often than not the target tends to be, in certainly the mental health system, persons with serious mental illness or serious emotional disturbance, and much to the chagrin of folks who have issues that are not as complex or demanding, but certainly need and benefit from treatment.

COUNCILMEMBER SHEWRY: I wanted to respond on the Healthy Families outreach issue. The Healthy Families program does anticipate expanding to cover the parents, the uninsured parents of children enrolled in the program sometime in the next budget year.

The community based outreach is going to continue. There is no cut proposed in that. The $12 million in contracts that the Department of Health Services, administers that is proposed to continue, as is the application assistance fee, which is paid when a trained community member helps a family enroll.

What was proposed to be cut is there won't be any media advertising for the parental expansion. When the

administration looked at how to save money in next year's budget, it was felt that the media campaign was the first thing that was able to be taken away. We wanted to make sure that the parents could enroll and that the person-to-person outreach stayed funded. So those are proposed to be retained in the budget, and the Legislature is looking at that as they go through the priorities.

CHAIRPERSON MAYBERG: Thanks, Sandra.

Don Larkin.

COUNCILMEMBER RICHIE: Dr. Mayberg, could I speak to her Bioterrorism issue briefly?

CHAIRPERSON MAYBERG: Yeah, but we do need to move on.

COUNCILMEMBER RICHIE: Okay, just to let you know, we've been hearing that HRSA had bioterrorism money for the clinics. But we haven't heard any details, and I've tried to find our.

What I think that we're hearing now is that it would be in the next federal fiscal year, but we're just not getting clear information on that.

As far as the assessment is concerned, that will be a countywide assessment, providers of all types will be included in that. There's been special attention given, I know, within the Department to the border communities and the issues with Mexico. We've got our fingers crossed

that maybe we'll get some specialized federal money for that, but we just don't know, at this point.

So the Mexico-California bioterrorism issues are very much a concern and are under discussion and taken really quite seriously.

CHAIRPERSON MAYBERG: Don Larkin.

MR. LARKIN: Good morning. My name is Don Larkin I'm the CEO of San Gorgonio Memorial Hospital in Banning, California.

I'd like to take just moment this morning to express some concern and also pose a couple questions regarding the LSHPD acute hospital construction permitting process.

My hospital has been working for over two years to complete a small addition, which is replacing our 50 year old obstetrical unit. This was, in addition, made possible by donations from many individuals in our community, organizations, the county and several large foundations.

So we have a limited budget, certainly. That budget was developed in the original estimates of what the projected would be.

We hired a qualified architect. We spent well over a year designing the project, looking at Title 22, Title 24 to ensure that we would meet those standards. We

then submitted the detailed drawings to the Department for approval. That process took a little over six months and did result in some changes in the original plans, which was certainly appropriate.

Once that process was completed, we took the project out for bid. We were able to hire a contractor and begin the process. It was estimated it would be a ten-month construction process. It's now in the 27th month. And a great deal of the delay has been caused by things we've had to change once the process of construction was begun.

These changes were requested by the field representatives, both Fire Marshal and OSHPD representatives, and have resulted in a large number of change orders having to be issued to the contract. In fact, we've got about a 20 percent overrun right now, which because of the nature of the funding has used up all the money, which was allocated for new equipment for this facility.

Therefore, we hope we're going to finish the process in about two to three weeks and then begin the licensing process. But to do that, we're going to have to lease the equipment now. And that's going to cause an additional financial burden to an already financially stressed facility.

My point is, why can't we develop a process for this, that once the plans have been submitted and gone through the lengthy approval process, we can depend upon that approval to go ahead and build our project, and not look at a lot of field changes as we're going through it, which become very costly.

There are contractors that won't touch an acute hospital project because of these changes. There are also contractors that plan on making a great deal of money because of changes that will be required through this process in acute hospital construction.

So that's the first question, what can we do to make this a better process? What can we do to assure facilities who have gone through the process of getting their plans approved, that they can build under those plans and won't have major changes made while they're under construction?

The second concern I have is we're looking at seismic retrofits to almost all of the facilities, I suspect, in this state, are those that won't end up closing. What are we going to do with this type of process as we're going through seismic retrofits. We've heard earlier testimony, and I think we all concur with that, they're just isn't the money to do it today. And if we're adding this type of overrun to those processes, how

are we going to make that work?

My question is can the system be modified so that as we move into these critical periods in the future of construction, we can depend upon approved plans to be used to build our projects or complete or projects and not go into these huge costs overruns.

Thank you.

COUNCILMEMBER CARLISLE: Thank you, Don for that question. This is Dave Carlisle, OSHPD Director.

I can't personally respond, I think, directly to a lot of the detail implicit in your question. But from what I do understand about the process, part of the reason that there is this iterative component is that often times changes lead to other changes that have to be reviewed and approved subsequently.

But today, we do have Kurt Schaefer here who is our deputy director in charge of the Facilities Development Division. And maybe you might want to speak to Kurt after the meeting or some more specific responses. I know that everyone is struggling with implementation of the Seismic Safety Act and changes, retrofiting requirements, and we're trying to streamline our processes so that we can be as responsive as possible to the facilities that have to make these changes.

We're aware that this is a challenge for the

facilities. We're in the process of bringing on additional staff for review of submissions and things like this to address the situation.

MR. GUNTHER: Charles Gunther, Eastern Plumas Health Care. We just completed or are attempting to complete, have occupied but having closed the file yet with OSHPD, on a new wing on our hospital that was originally budgeted for $2.7 million and nine months of construction. It's taken 25 months and $4.5 million.

Having dared to undertake this project might be the demise of our facility by virtue of the cost overruns, the delays, the lost revenue, et cetera. We've had considerable discussion with the Department. I want to thank the Department for listening to our concerns and Kurt Schaefer, in particular, for attempting to find some solutions to this process.

But I do want to emphasize that it is a critical issue for small rural hospitals. I think too often we have inconsistencies between regions and interpretation and applications of codes. We have extensive delays in the construction project while we attempt to get clarification. I know Kurt has worked on a process to get more timely response to appeals of field decisions. I think that would be extremely helpful.

But I would hope that the Department would be

particularly sensitive to the plight of small rural hospitals who have really, in these cases where we've attempted to do construction projects and implement seismic improvements. We have stretched ourselves to the very limit to do the project to begin with.

We simply can't afford a cost overrun or a delay and we'd ask the office to continue to work with us in finding some solutions to this problem.

CHAIRPERSON MAYBERG: Very articulate late explanations of what the real costs are of delays.

Raymond Hino.

MR. HINO: Thank you and good morning. My name is Raymond Hino, and I'm the Chief Executive Officer for Tehachapi Hospital in Kern County. We're the third hospital designated as a critical access hospital in the State of California. Our anniversary date that's coming up is April 1st, so we're one of those four hospitals awaiting recertification.

We appreciate all the support that we received from the State and the federal government to become a critical access hospital. I can definitely say that without this important program, our doors would have closed by now. Had we closed, the more than 30,000 people in our area would be left without an emergency department within a radius of 40 to 50 miles.

We see on average over 800 emergency room patients per month. Today I'm here to speak to you about the problem of emergency department saturation diversion and closures due to staffing shortages, lack of planning and fear.

In a recent study, this one, at Tehachapi Hospital, we noted that over 200 patients were transferred out of our facility during a four-month period. That's an average of 50 per month. For those 200 plus patients who are required to transfer out for a higher level of care, the average waiting time to transfer out a patient was five hours.

Nearly half, 76, of those waited over five hours. The reason for the delay is, as you know, we're required to receive an approval from a receiving hospital to transfer a patient. The majority of the time the approval is denied by our closest urban hospitals due to emergency department saturation, rotation, closure, et cetera.

What we do in our emergency department is we have a map with concentric circles. The circles are small and get larger and larger and larger. If all of the hospitals in Bakersfield, our closest urban transfer area, deny our requests, then we go out another circle. We start going into LA County. We're closed to LA County and Lancaster and the Palmdale area.

If we're denied in LA County, at least that part, we go out another circle and we start calling Fresno County, we start calling inner-city Los Angeles hospitals. Of those 200 transfers I talked about a moment ago, 14 of them went out of county.

This is not a problem specific to Tehachapi Hospital. My colleague David Green, CEO of Kern Valley Hospital, another rural hospital in Kern County, reports similar problems, nor is the problem limited to Kern County.

Recently, the Hospital Council of Northern California and Central California commissioned a study of the Sacramento area. The study was completed by the Averis Group. Among the findings of the report are, that a confidential process should be designed to verify hospital opportunities and the steps taken for improving flow and capacity and make recommendations on the plan of action.

Also, develop, monitor and enforce a standardized and uniform divert policy for adoption by all hospitals, and, a particularly important one, California statutes should be revised in key areas to provide more flexibility on key issues that limit capacity, including EDD department, destination, medical nursing ratios and additional licensed beds.

For those of you with a medical background, I'm sure that you can appreciate the disaster that can occur when a patient takes five hours or more to be transferred out of a rural hospital into a full service hospital with surgical specialties and surgical capability around the clock. I could tell you horror stories of patients that have literally crashed in our emergency department, and our staff have stood helplessly by doing everything they can to save that patient when hospital after hospital after hospital denies our request for transfer.

Thank you.

COUNCILMEMBER SMILEY: The issue that you raise, I think, is absolutely correct. It's not limited to Kern County. It's a statewide phenomenon that is being seen. And I can tell you that the administration and the Legislature are all very interested in trying to assess and find whatever solutions may be available.

However, I can say that it's, as you know a very complex problem, and one that affects emergency care, not only in the pre-hospital side but also in the emergency and trauma care side as well, too. And the issues that you raise are certainly valid.

One of the things that, at the Emergency Medical Services, we're looking at in conjunction with Department of Health Services is to try to assess, to the degree

possible, what interventions can be taken. Some of the issues that we are considering is trying to really study the problem on a statewide basis.

And one of our hopes, at some point, would be to develop some sort of an ongoing RealTime assessment of hospital diversion and hospital capacity. One of the things that might be considered would be some sort of a readinet type system. I'm not sure how many hospitals have that within the county. But Los Angeles County, for example, has a readinet system, so that the County and each hospital can see what the bed status is throughout the entire county at any given time.

And I think that if we're able to develop some sort of a statewide communication system and some sort of an ongoing monitoring mechanism, we'll be able to get a better handle on what some of the issues might be.

Clearly, the workforce issues that have been previously enunciated by many other people is a factor, and it's something that we're very, very interested in looking at as well too. And I can tell you that there are a number of bills, legislative bills, out there this year and perhaps even some initiatives that might be on the table to try and address this issue.

So I don't have any answers, but I can tell you that you're not alone in this.

CHAIRPERSON MAYBERG: Speranza.

MS. AVRAM: Thank you. I'm Speranza Avram with the Northern Sierra Rural Health Network. And there's actually a couple of things I want to talk about.

One is a follow up to a process that happened last year under the leadership of the Rural Health Policy Council to review the definition of rural and to look at the MSSA boundaries, Medical Service Study Area boundaries in response to the 2000 census.

The process that was completed last year was to update the definition of rural and also to add a frontier definition to the State of California's process, which is 11 persons and under.

And then the recommendation of the task force was to review MSSA boundaries in light of the new 2000 census data, which I recognize OSHPD is currently crunching the numbers to get a look at what they are going to be, and then a commitment to reconvene the rural definition task force to then take a look at the whole issue. So I wanted to get an update on where that process was at.

But before I let go of the microphone, I also wanted to respond to Dr. Mayberg's comment about mental health, and the mental health services that are provided, not just at the county level, but also within both FQACs and our HC's 95, 210.

And those providers are, if you will, carved out of the carve out of mental health. And there's been a lot of discussion, particularly in the north part of the State where I work about the relationship and the levels of care that patients are getting as they move between those systems, the primary care behavioral system, where people do go when they're not seriously mentally ill and have a lot of mental health issues, they go to their family physician, their primary care clinic and do receive mental health services that are paid for by Medi-Cal, including the services of an LCSW, as well as a clinical psychologists.

I want to take this opportunity to invite, particularly providers of the north State, to a mental health care summit that we're working on with the California Institute of Mental Health, as well as the Mental Health Directors Association. That will be April 26th in Chico from 9:00 to 4:00. And you can go to the CIMH web site to register.

It will be an opportunity for primary care providers who are concerned about mental health to have a dialogue with the county mental health systems, as well as representatives from the State. And I think all the key agencies have been invited to really begin a dialogue of how to address the mental health issue in rural

California, because it's really time to do that. And that we all have the same goal in providing quality care to patients, and we're really under-utilizing opportunities for collaboration. And that's really what we want to start talking about to move forward.

But then I did want to hear about the Rural Definition Task Force.

Thank you.

COUNCILMEMBER CARLISLE: Thank you, Speranza.

As most of you know the Medical Study Services Areas in California are really created to address health care, workforce and shortage areas from the State of California. And, of course, the 2000 census has greatly impacted the definition of those areas.

And we've worked, the office has worked, with a number of you all to try to make sure that our definitions of these study areas are really responsive to the needs in particular communities. And we try to, on an ongoing basis, sort of tune those definitions to reflect evolutions in those needs.

At the last Health Care Manpower Policy Commission meeting, the Commission basically asked the office to reconstitute a task force to work on this definition process. And I think, at this point, we've not had a first meeting of the task force, but we're still

putting it together. And I think it will be meeting very shortly.

This is an ongoing process. It's about really to get off the ground very shortly. We hope to have some answers very shortly for people that are really focused on that.

Thank you.

CHAIRPERSON MAYBERG: Speranza has been a real advocate for mental health in rural areas, and was just at my Senate budget hearing pushing the issue. And I love to have that kind of stuff, because it does make the system work better.

David Green.

MR. GREEN: Thank you. I'm David Green. I'm the CEO of the Kern Valley Health Care District in the Kern River Valley, about 50 miles upstream, up a winding narrow road up in the mountains above Bakersfield, just a couple mountain ranges over from Ray, who was just speaking on the subject of the emergency medicine dilemmas, what we currently have.

I wanted to address the issue of keeping our small rural hospitals alive, given all of the issues that we've discussed above, but I wanted to touch on the subject of managed care.

Before I get there, I just want to reiterate that

each one of the issues that we've been discussing are all tied to the dilemma of keeping our small rural hospitals alive and pulling these issues together in some type of solutions is the only way we're going to keep things going.

My hospital, currently, sits on $20 million dead burden for an $8 million project started about ten years ago, with the same issues that Don Larkin was discussing. The overruns there basically took an $8 million project, cost us $20 million for half the project and we've had revenue short falls. And certainly Cal Mortgage has done very good in working with us in trying to make things work at the institution since then.

In addition, as Ray pointed out, the emergency systems, the threat of intalla violations are always over our head. We're a small rural hospital. We have people -- we're trying to save their lives and trying to get them to places. And sometimes we have to go to extraordinary measures.

So we constantly have that intalla threat over our heads. The intalla threat goes both ways. However that's the one that the tertiary centers always use, you cannot send them here. And, you know, the question is are we supposed to let the patient die and then we all get sued.

But the issue is still acute in that arena. And I just want to reiterate that. I want to address the further problem of managed care.

In our area, especially in Kern County, there are two organizations that have basically taken the PPO part of managed care and basically taken a provider service contracting part. And with that, I'm sure we're not alone in this situation, where we have two managed care players that are basically directing who will and won't do certain services.

And all I'm asking, is there anyway to enforce, we have a Department of Managed Care, some of the rules that already exist in reasonable distance to have certain services. We have the ability to provide many services at our institution that our residents are told know they have to drive down this narrow windy road for an hour, hour and a half to get to another place to have those procedures done and.

That, in essence, has weakened the structure of our facility to be able to provide some of those services.

And it also is encouraged or discouraged to specialists from coming up and doing services that can be done in our institutions in the remote and rural areas.

So the dilemma we have is that managed care is playing an impact, downsizing us to basically an ER and a

basic care service, but we're no longer going to be able to maintain those services with all of the other issues that we've just mentioned that are coming up, seismic safety being own one of them, unless there's someway to assure that we can, at least, give to our local residents the services that we're able to give at our institutions that we currently have.

And speaking as an advocate for the local resident, I think it is drastically inappropriate for institutions to be allowed or institutions of money or managed care to tell the residents in my valley that I'm sorry you can't have some basic services, even like EGB scopes, you have to drive down to the tertiary centers in the metropolitan areas to get some of these basic services.

The ability for our facilities to offer these to our local residents not only gives them the service, but it also bolsters the economic feasibility of keeping our operations alive.

And that is primarily what I wanted to address. Is there anyway to assure that we can continue through the managed care debacle of reimbursement in addition to the rest of the issues that we're already dealing with.

EXECUTIVE DIRECTOR LEE: Ray, could I ask you, first of all, let me get your card after this. Is this a

common phenomenon across the rural communities, Jim?

MR. HAAS: Jim Haas, Executive Director of Mountains Community Hospital.

We had a managed care organization called Inland Health Organization, IHO, in San Bernardino. They were providing services to about 3,700 estimated residents up in the San Bernardino mountains.

They were there in our area as long as the providers subsidized them with unreasonably low rates. For, us in, our situation we were getting reimbursed 17 cents on the dollar. Two years ago we said we can't live with this, spent three months trying to negotiate a fair and reasonable rate of reimbursement, unsuccessful, and put in place what eventually occurred just in the last week and a half two weeks.

We cancelled the contract and people still continue to consume locally, particularly the emergency room. Instead of 17 cents on the dollar, IHO then began paying us an out-of-network rate based upon our contracts with other payers, and we got a reimbursement of up to about 50, 52 cents on the dollar.

But that put them in the situation where they could no longer economically make a profit and serve those residents, so they just decided to pull up stakes and move off the mountain.

That's probably good news for us in our situation. But for the people who are living on fixed incomes for the senior HMO recipients, those people who are now put in a position of having to find some other means of providing coverage over and above the Medicare program are really stuck and faced with a major disruption to the way they access health care.

EXECUTIVE DIRECTOR LEE: Okay. Thank you, Jim.

COUNCILMEMBER STAINES: I'm Morgan Staines from the Department of Alcohol and Drug Programs. And managed care is something I know something about. It's not part of my Department.

But the Department of Managed Care has a very active sort of an ombudsman program. And I don't know if they're really set up to address provider concerns, certainly about contracting issues and things like that, but they are definitely oriented to assisting patients. And if your patients are not plugging into that when they have issues, they should be, because that's, you know -- you know perfectly well it's the squeaky wheel the gets the grease.

So if you're not making input into that system, you should be, because they are active in trying to address these issues. They need to know that they're there and I don't know, to what extent, they're familiar

with your issues.

EXECUTIVE DIRECTOR LEE: If I could just ask that Ray and Jim and then anybody else that has a similar situation like this that they'd like to concern where we could pull together some kind of a group effort, probably via conference call, so we don't have to hall you down here all this way just for one meeting, but we do know folks over at DMHC, that at least we can get to them and have a dialogue if that would be a start of a dialogue, that would be of help.

So I'll take Jim and, you know, Ray as a subcommittee of two and if anybody else want to join us, just let me know.

CHAIRPERSON MAYBERG: Gloria Grijalva.

MS. GRIJALVA: Good morning. Mine is a question. I don't know if anyone has any answers yet. But President Bush's recent announcement regarding the extension of amnesty to previously undocumented workers has the possibility of impacting those rural areas who are already struggling, as you've heard here, already.

Is the Council involved in any kind of activities, information gathering as to how to deal with this population, who are probably farm workers, who will now feel comfortable actually coming forward, or is there already a program underwhich they will probably qualify?

CHAIRPERSON MAYBERG: I don't think we will pay attention to that. I think we still have to deal with our California laws that may conflict with the federal amnesty issues. We still have to deal with our propositions and who can get service and who can't. And those have been uphold in court.

So it does put providers in a very difficult position in terms of how to provide service.

Teresa Jacques.

MS. JACQUES: Good morning. My name is Teresa Jacques. I'm the administrator of Modoc Medical Center in Alturas, California. And while my issue today seems small in comparison to some of the other issues that rural hospitals are facing, it still adds to the frustration level of trying to get the cash from the State that our hospitals are due.

And my issue today is inpatient TARs. In 1993, we appealed two TAR decisions that were denied. And in December of 2001, we got those decisions back. And since I've been in Sacramento for the last two days, I've heard of other rural hospitals who are now getting responses from the State that are approximately eight years old.

And I just wonder if somebody could look into this issue of such a slow delay in responding to our appeals.

CHAIRPERSON MAYBERG: We will look into it.

COUNCILMEMBER RICHIE: This is the first I've heard of it, but I'll get back and talk with our Medi-Cal staff and see why all of a sudden you're hearing back on eight-year old claims.

CHAIRPERSON MAYBERG: The last question is from Vic Biswell who already asked a question.

Is there any anybody else who has any questions, some of us have an 11:00 o'clock meeting.

CHAIRPERSON MAYBERG: Vic, this is 0 for 2 for you, so you better be really, really on and turn this group around.

MR. BISWELL: I'm Sharon Avery.

(Laughter.)

MR. BISWELL: I want --

CHAIRPERSON MAYBERG: You need to work on those hormones there.

(Laughter.)

MR. BISWELL: I wanted to remind the Council of a basic fact, and that is economies of scale. I'm going to tell you about a little hospital that drops its bills within three days. It's days in accounts receivables are less than 62. And in terms of deductions from revenue, it is about 24 cents on the dollar.

Those are all pretty good statistics and they

suggest that this little hospital is functioning pretty darn well. But it can't quite meet its fixed costs, because it's volume and what it is paid for services just don't match up.

As a critical access hospital, it would gain little because of -- primarily because of patient mix. If, however, in the infinite wisdom of the State, they were to participate in the critical access program, this hospital would survive.

Thank you.

CHAIRPERSON MAYBERG: Thank you, Sharon.

(Laughter.)

CHAIRPERSON MAYBERG: I want to thank all of you for the comments and the concerns and the issues that, as you can see, some of the issues that you brought to our attention were things that we weren't aware of. It gives us an impetus to go back and to look how to make the system better. Some of them are longstanding problems.

But I leave these meetings always with a profound admiration for what all of you do in terms of making the system work and providing services in rural communities under often times very, very challenging conditions, and making it happen in ways that always amaze me, how you survive from crisis to crisis, but you do and you're a model for all of us.

So thank you very much for coming.

(Thereupon the California Rural Health Policy Council adjourned at 10:45 a.m.)

CERTIFICATE OF REPORTER

I, JAMES F. PETERS, a Certified Shorthand Reporter of the State of California, and Registered Professional Reporter, do hereby certify:

That I am a disinterested person herein; that the foregoing California Rural Health Policy Council meeting was reported in shorthand by me, James F. Peters, a Certified Shorthand Reporter of the State of California, and thereafter transcribed into typewriting.

I further certify that I am not of counsel or attorney for any of the parties to said meeting nor in any way interested in the outcome of said meeting.

IN WITNESS WHEREOF, I have hereunto set my hand this 4th day of April, 2002.

JAMES F. PETERS, CSR, RPR
Certified Shorthand Reporter
License No. 10063